COMMITTEE PRINT

EMPTYING THE ELDERLY'S POCKETBOOK— GROWING IMPACT OF RISING HEALTH CARE COSTS

A REPORT

BY THE

CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MARCH 1990

Comm. Pub. No. 101-746

Printed for the use of the Select Committee on Aging

This document has been printed for informational purposes only. It does not represent either findings or recommendations adopted by this Committee.

U.S. GOVERNMENT PRINTING OFFICE

26-964 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H142-5

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

THOMAS J. DOWNEY, NEW YORK
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, JR., Michigan
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
BEN ERDREICH, Alabama
NORMAN SISISKY, Virginia
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
RICHARD H. STALLINGS, Idaho
JAMES McCLURE CLARKE, North Carolina
JOSEPH P. KENNEDY II, Massachusetts
LOUISE M. SLAUGHTER, New York
JAMES H. BILBRAY, Nevada
JIM JONTZ, Indiana
JERRY F. COSTELLO, Illinois
HARLEY O. STAGGERS, JR., West Virginia
FRANK PALLONE, JR., New Jersey
JOLENE UNSOELD, Washington
PETER A. DEFAZIO, Oregon
JOHN LEWIS, Georgia

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
THOMAS J. TAUKE, Iowa
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PAUL B. HENRY, Michigan
BILL SCHUETTE, Michigan
FLOYD SPENCE, South Carolina
WILLIAM F. CLINGER, JR., Pennsylvania
CONSTANCE A. MORELLA, Maryland
PATRICIA F. SAIKI, Hawaii
JOHN EDWARD PORTER, Illinois
JOHN J. DUNCAN, JR., Tennessee
CLIFF STEARNS, Florida
CRAIG T. JAMES, Florida

RICHARD A. VELOZ, M.P.H., J.D., *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

TABLE OF CONTENTS

	PAGE
Preface by Chairman	v
Executive Summary	vii
Introduction	1
Rapidly Rising Health Care Costs	3
Slow Growth in Elderly Income	15
Elderly Losing Ground as Health Care Costs Absorb Higher Percentage of Their Income	23
Conclusion: "Consumer Cost" Containment as Critical or More than Federal, State and Employer Cost Containment	33

PREFACE

The story portrayed in the attached House Committee on Aging study is one of people -- lower and middle income older Americans -- and the pressures they face from a society-wide problem -- rapidly rising health and long term care costs. While virtually all lower and middle income Americans feel some pressure from these costs, the problem is acute for people whose incomes rise no faster than overall inflation. It is acute for those who have high out-of-pocket health costs or who are at high risk of facing high costs. When these two factors come together as they do for older and lower/middle income elderly, the problem can become unbearable. The elderly's pocketbooks are quickly being emptied as the elderly face spending twenty percent of their income on health care.

The study's result dramatically points out the great need for change. Change in how the nation contains its health and long term care costs is long overdue. Federal, state and employer actions have been relative failures in their primary objective, containing their own costs. Their actions have been too narrow in their application, failing to protect elderly and non-elderly consumers from costs uncovered by public or private third party payers.

As the final chapter of the study suggests, a comprehensive system of cost containment is essential if costs are to be kept affordable for all Americans, including the uninsured and underinsured of all ages. The failure to do comprehensive cost containment will fall most heavily on younger Americans with little or no insurance and on older Americans with lower, relatively fixed incomes.

A nation's respect for all its elders comes from what they did, their contribution to a free and strong America, and from who they are, proud people delicately balancing their own needs with those of their grandchildren and children. Our elders ask no undue attention, only that attention necessary to survive the special trials of later years. They ask only to be treated fairly. They ask only to retain their dignity and independence. They ask only for society to recognize the extra pressure on the elderly facing high health care costs with only limited incomes.

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

EXECUTIVE SUMMARY

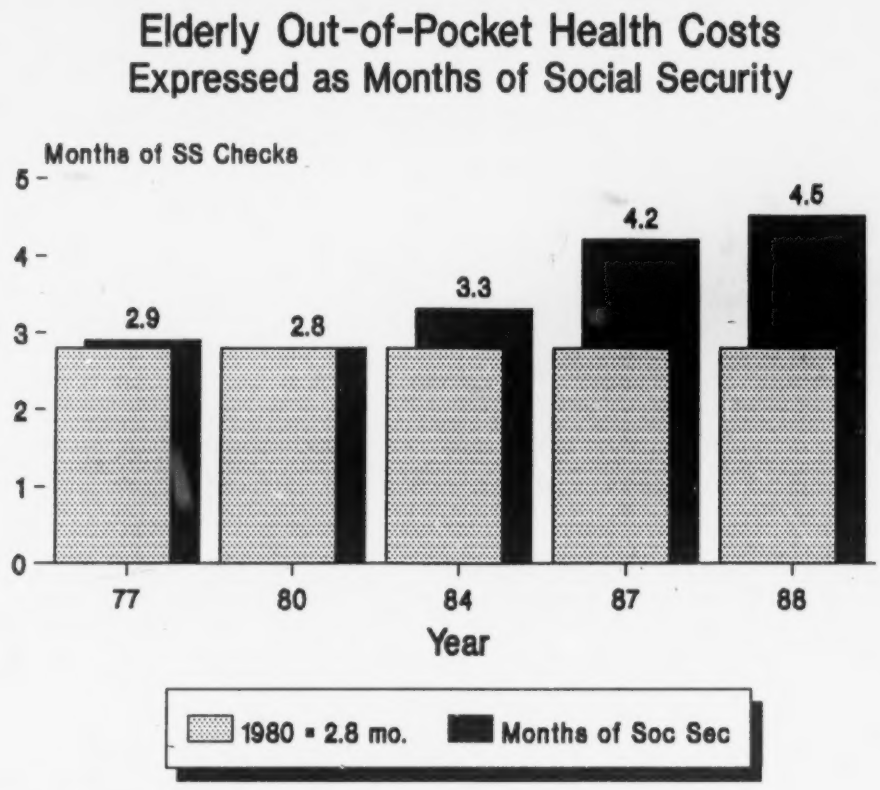
The elderly today, on average, are somewhat better off in terms of income than previous generations of elderly. However, the same data suggest large numbers of elderly, including older women and racial and ethnic minorities are still in deep trouble. The data also suggest that the retirees of the 21st century, on average, will not be better off. Any advantage that the elderly may have by entering retirement with higher incomes than a decade ago will quickly be lost as health and long term care costs absorb ever larger proportions of that income.

Measured against a number of indicators of income, health and long term care costs are, on average, absorbing ever larger percentages of elderly income. For elderly persons entering retirement in any given year, they face a continual erosion of their income as health care costs rise more than one and one-half times faster than their income. Elderly out-of-pocket costs have risen from 12.3 percent of elderly income in 1977 to 18.2 percent of income in 1988. (See Figure E.1) All indications are that this trend of costs outpacing income will continue into the foreseeable future and that health costs are likely to reach 20 percent of elderly income by the early 1990s.

For the average senior citizen receiving Social Security, it is taking more and more of their Social Security checks to cover health and long term care costs. In 1977, the average senior citizen used just under three months worth of checks to cover his or her out-of-pocket health care costs. (See Figure E.2) By 1988, it took the average senior citizen four and one-half months worth of checks to cover those health costs.

As for other health cost indicators, the Medicare Part A hospital deductible jumped from $124 to $540 -- over four times the level in 1977 and twice the one-half month Social Security payment for 1988. Medical price increases for the past seven years are also much higher than increases in several indicators of elderly income. Between 1983 and 1989, medical prices increases rose twice as fast as did the average monthly Social Security payment and the Consumer Price Index for Urban Wage Earners (CPI-W), the basis for setting Social Security COLAs.

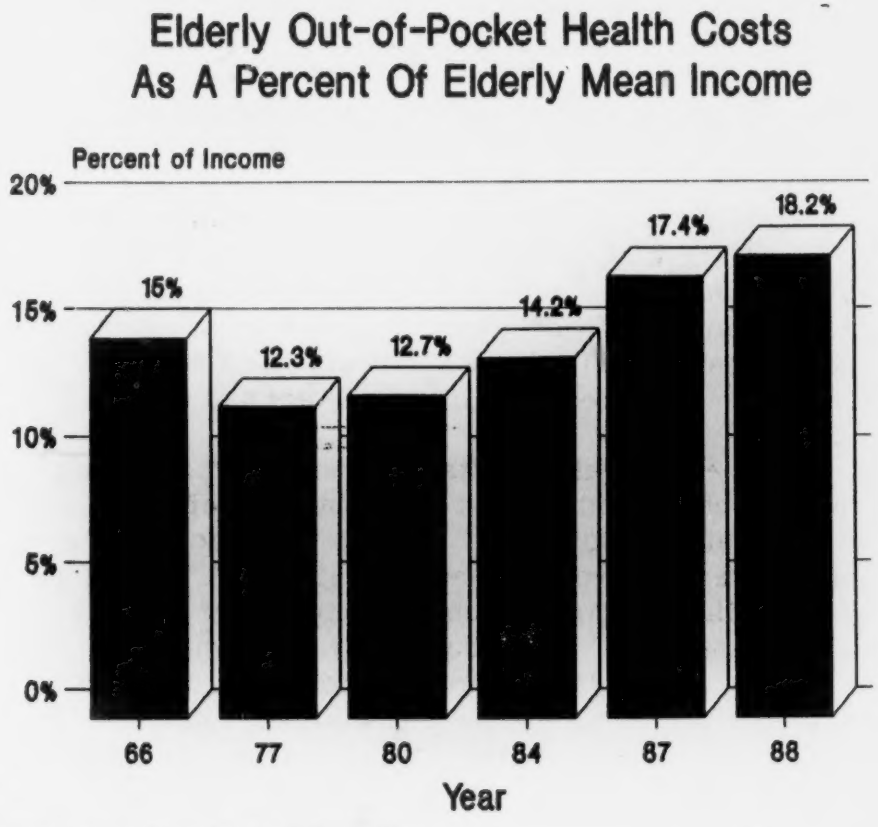
FIGURE E.1 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS EXPRESSED AS NUMBER OF MONTHS OF SOCIAL SECURITY PAYMENTS (Average Monthly Benefits (Current-payment Status) for Retired Workers) FOR 1977, 1980, 1984, 1987 AND 1988.



Source: House Committee on Aging, 1990, and U.S. Social Security Adm., 1990

Looking ahead, the President's 1991 Budget proposes a permanent increase in the Part B premium by tying it to increases in overall Part B costs, increases that are almost always higher than Social Security COLAs. Under his best case where he gets all of his other Part B cuts, the premium would rise an average of 9.6 percent annually as compared to average Social Security COLAs of 3.7 percent. If Medicare Part B is not cut as he proposes, the premium would rise an average of 10.0 percent annually. In both cases, the elderly lose ground. Another source of concern is over the access and quality consequences for the elderly if the President does get his other Medicare Part B and Part A cuts.

FIGURE E.2 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS AS A PERCENTAGE OF ELDERLY INCOME FOR 1977, 1980, 1984, 1987 AND 1988.



Source: House Committee on Aging, 1990

While elderly mean income has experienced some growth in the 1980s, other groups have much higher incomes which have grown faster. For example, mean incomes for physicians, a primary source of health care for older Americans, has grown much faster. Starting from a level of $89,900 in 1981, average physician net annual income rose to $144,700 in 1988. During the same period, elderly mean annual income went from a level of $8,738 in 1981 to $13,131 in 1988 and is only one-eleventh the level of physician net income.

As this analysis clearly documents, the elderly, as well as any other group of people with relatively fixed incomes and substantial health care costs, have a problem now and are likely to have a bigger problem in the future. Though the problem is acute for all low and middle income elderly, it is particularly acute for those living in the "high risk zone," a place where incomes are limited and health care costs may be high.

Unless there is a significant cost containment intervention on behalf of beneficiaries, there is every reason to believe that future is likely to look much like the past where health care costs grow everywhere from one and one-half to two times faster than both general inflation and elderly income. Unless policies change, there will continue to be no significant cost containment effort to restrain out-of-pocket costs for Medicare beneficiaries and to restrain out-of-pocket costs for the uninsured and for those not represented by employers and unions.

While federal and state governments and employers and unions continue cost containment efforts, what is missing and desperately needed is a coordinated cost containment approach that restrains cost for all payers, whether they be government, employers, or individuals. To be successful, a coordinated strategy must be applied fairly so that health care providers receive reasonable payment for their services. It must be applied with great care to ensure that health and long term care quality and accessibility do not suffer.

NOTE: For further information on health care costs and the elderly, contact Gary Christopherson, Yvonne Santa Anna or Carolyn Griffith at the House Select Committee on Aging, Room 712, House Annex 1, Washington, D.C. 20515. Phone: 202-226-3375.

INTRODUCTION.

Today almost everyone agrees that health and long term care costs are rising faster than is our ability to pay those costs. Much of the attention has been focused on federal expenditures over the last decade. During that same period, less attention was focused on costs paid by the elderly and other consumers Recently, more attention has been focused on the impact of rising health care costs for both employers and employees.

America's elderly are in a fairly unique situation. Those costs not covered by Medicare or Medicaid are rising much more rapidly than is their income. However, the elderly are also at risk as federal and state governments try to rein in their Medicare and Medicaid costs. To date, Congress has turned back attempts to greatly increase the elderly's share of Medicare costs. However, the Medicare Part B premium, a frequent target for major increase, has been increased more than the annual adjustment in Social Security payments. The Part B premium has been tied to increases in Part B costs in recent years rather than increases in Social Security cost-of-living-adjustments (COLAs) as in past years. The President's 1991 budget proposes to permanently tie the premium to the more rapidly rising Part B costs.

In the case of employer-based retiree benefits, employers are facing similar cost pressures for these costs as for their active worker benefits. Again older retirees who were counting on private retiree benefits to help pick up some of their health benefit costs are increasingly at risk as employers try to constrain their rising health insurance costs. This problem is exacerbated as private pensions either have no cost-of-living-adjustments (COLAs) or have adjustments running less than inflation. Under the President's 1991 budget, most Federal and military retirees would face a freeze in the 1991 COLA and a limit on future COLAs to the Consumer Price Index minus one percent.

What follows is an assessment of the health cost pressures facing many Americans, but with a focus on elderly Americans -- a group with higher health care costs and less growth in their income. This assessment could equally be applied to any other group whose income fails to match inflation and whose health is poorer. For those elderly relying primarily on Social Security, their income grows at about the rate of regular inflation. Those elderly who rely on pensions for all or part of their income are in no better position. For their pensions, they generally get no inflation adjustments or only get inflation adjustments equal to or less than regular inflation.

The problem arises from the fact that health care costs generally rise much faster than other costs of living and than cost-of-living-adjustments for elderly income. When the House Select Committee on Aging conducted its study in 1989 of elderly health care costs, the results documented the rising impact of health care costs on America's elderly. Over the late 1970s through the late 1980s, health care costs rose from 12.3 percent of income in 1977 to 18.2 percent of income in 1988. Preliminary projections are that this percentage will rise to over 20 percent in the early 1990s with or without the Medicare Catastrophic Coverage Act.

RAPIDLY RISING HEALTH CARE COSTS.

Rapidly rising health care costs have been a fact of life for this country for the past two decades. In spite of a host of private and public sector efforts to hold down the rate of increase, health care costs continue to rise at very high rates. Further, there is is little evidence that the trend is changing significantly.

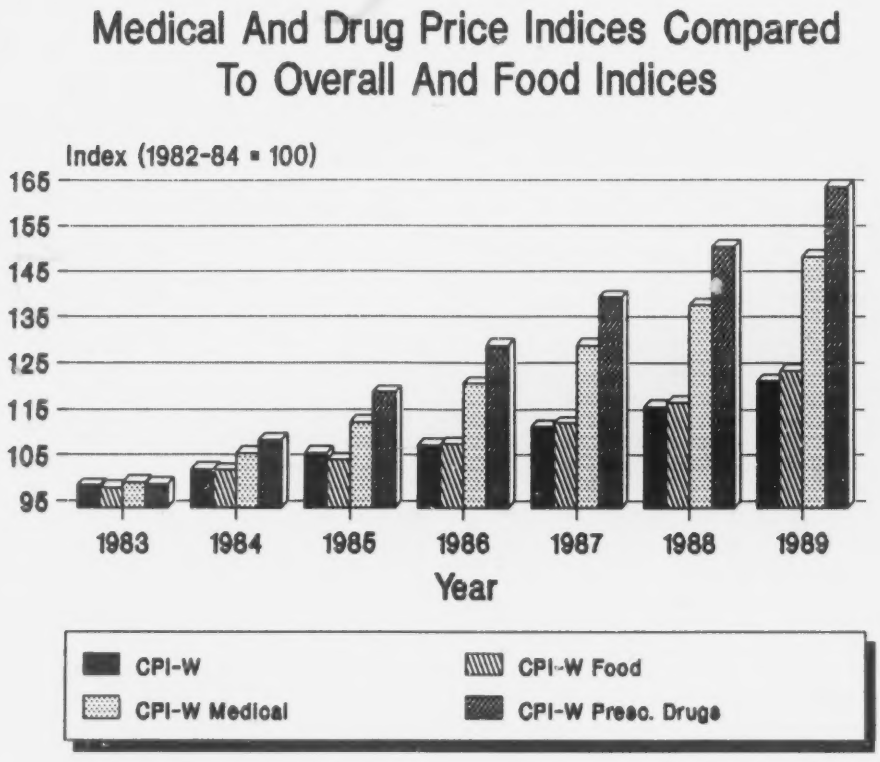
Much has been written in recent years about the public sector's efforts to constrain costs. Most of the attention has focused on Medicare, the most visible of federal health care programs. Medicaid went through substantial cost containment in the early 1980s and has since received less attention as it has been overshadowed by Medicare. Employers and labor unions went about the task of reining in their health care costs, only to find that for all their efforts, relatively little was accomplished. Health care costs continue to rise much faster than almost any other sector of the economy and show no substantial sign of slowing their rate of increase.

CONSUMER PRICE INDICES. One useful indicator of the upward spiral of health care costs is the consumer price index. As part of that index, the Bureau of Labor Statistics lists a number of health care price indices which can be compared to prices in other sectors of the economy.

For purposes of this discussion, the focus will be on the trends since 1983. However, the trends for the 1983 through 1989 period do not look appreciably different than the trends for earlier times.

The Consumer Price Index for Urban Wage Earners, the index used in calculating Social Security cost-of-living-adjustments, has grown from an index level of 99.8 in 1983 to a level of 122.6 in 1989 -- about a 23 percent increase in six years. Over those same six years, food prices rose just a slight bit faster (from a CPI-W level of 99.4 to 124.8) -- about a 25 percent increase. Health and long term care prices rose at a substantially higher rate. (See Figure 1.1 and Table 1.1)

FIGURE 1.1 — COMPARISON OF TRENDS IN THE OVERALL CONSUMER PRICE INDEX (URBAN WAGE EARNERS) WITH TRENDS IN THE INDEX FOR MEDICAL CARE, PRESCRIPTION DRUGS AND FOOD. *



Source: U.S. Bureau of Labor Statistics, 1990

* The overall CPI-W index is used to help determine the Social Security COLA on a year-to-year basis.

TABLE 1.1 — CONSUMER PRICE INDEX (URBAN WAGE EARNERS) FOR 1983 THROUGH 1989. (Note: CPI-W for 1982-84 equals 100 and is the base for the index.)

Year	Overall CPI-W	Food CPI-W	Medical CPI-W	Prescr. Drug CPI-W	Phys. Care CPI-W
1983	99.8	99.4	100.5	100.1	100.1
1984	103.3	103.2	106.9	109.8	107.1
1985	106.9	105.4	113.6	120.1	113.4
1986	108.6	108.8	122.0	130.3	121.6
1987	112.5	113.3	130.2	140.8	130.5
1988	117.0	117.9	139.0	151.8	139.9
1989	122.6	124.8	149.6	165.0	150.3

SOURCE: U.S. Bureau of Labor Statistics, 1990.

From 1983 through 1989, the Consumer Price Index (CPI-W) for medical care rose from an index level of 100.5 to 149.6 -- a six year increase of 49 percent. This is over twice the increase as of overall prices or food prices. Physician care, a high proportion of what makes up the medical care index, rose at just a slightly higher rate than the medical care index. The index for hospital room prices went up slightly faster (about 55 percent over the six years) than the physician index. Among the fastest growing areas of health care prices is prescription drugs. Over the six year period from 1983 through 1989, that index rose from 100.1 to 165.0 -- nearly a 65 percent increase. As compared to overall consumer prices or food prices, prescription drug prices have grown over two and one-half times faster.

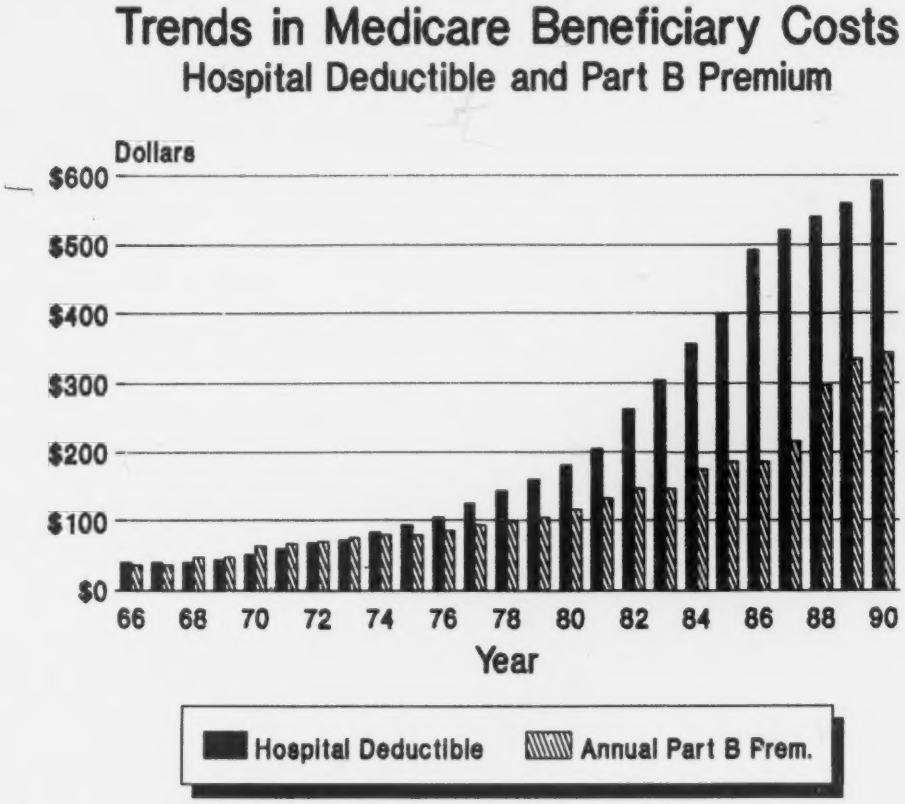
There is also no indication that these trends are likely to change. Focusing on changes over the last year, the overall Consumer Price Index (CPI-W) rose 4.8 percent. At the same time, physician care prices rose 7.5 percent; prescription drug prices rose 8.7 percent; and hospital room prices rose the most, a 10.0 percent increase from 1988 to 1989. Overall, the composite medical care price index rose 7.6 percent -- over one and one-half times faster than the Consumer Price Index (CPI-W).

PHYSICIAN FEES. Recent data released by the American Medical Association ("Socioeconomic Characteristics of Medical Practice 1989", AMA, 1990) provides further detail to increases in physician fees. Their numbers are slightly lower but fairly similar to the figures provided by the Bureau of Labor Statistics. The AMA's estimates show that the average physician fee for an office visit with an established patient rose from a 1982 level of $23.49 to a 1988 level of $33.91 -- an average annual increase of 6.3 percent.

MEDICARE PREMIUMS, COINSURANCE AND DEDUCTIBLES. Another view of rising health care costs for the elderly is provided by looking at trends in Medicare premiums, coinsurance and deductibles. With respect to coinsurance, Medicare requires beneficiaries to pay 20 percent of the "reasonable charges or costs." That means that this coinsurance rises as fast as does Medicare Part B costs, of which one indicator in recent years has been the Medicare Part B premium. In the case of hospital and skilled nursing facility coinsurance, both are tied to changes in the Medicare Part A hospital deductible. As is described in this section, the Part B premium and the Part A hospital deductible have both grown at very rapid rates.

In the case of the Medicare Part B deductible, the increases since the program's inception have been modest, growing from an initial level of $50 (1966-1972) to $60 (1973-1981) to $75 currently (1982-present). In the case of the Medicare Part B premium and the Medicare Part A hospital deductible, the story is one of large increases since the program began in 1966. (See Figure 1.2)

FIGURE 1.2 — TRENDS IN MEDICARE ANNUAL PART B PREMIUM AND ANNUAL PART A HOSPITAL DEDUCTIBLE FOR 1966 THROUGH 1990.



Source: Health Care Financing Adm., 1990

When Medicare began in 1966, the Medicare Part A hospital deductible was $40. * By 1990, that deductible had increased to $592 -- almost 15 times the level when Medicare began. (See Table 1.2)

---

* The Medicare Part A hospital deductible is an amount which a beneficiary pays for each benefit period, tied to stays in a hospital for an illness. Beneficiaries may be liable for more than one hospital deductible in a given year. Further, the hospital deductible serves as the basis for also calculating hospital coinsurance (1/4 of the deductible for the 61st through 90th day in a hospital and 1/2 of the deductible for the 60 lifetime reserve days) and skilled nursing facility coinsurance (1/8th of the deductible for the 21st through 100th day).

TABLE 1.2 — MEDICARE BENEFICIARY PART B PREMIUM AND PART A HOSPITAL DEDUCTIBLE FOR 1965 THROUGH 1990.

Year	Monthly Part B Premium	Annual Hospital Deductible
1966	$3.00	$40
1967	3.00	40
1968	4.00	40
1969	4.00	44
1970	5.30	52
1971	5.60	60
1972	5.80	68
1973	6.30	72
1974	6.70	84
1975	6.70	92
1976	7.20	104
1977	7.70	124
1978	8.20	144
1979	8.70	160
1980	9.60	180
1981	11.00	204
1982	12.20	260
1983	12.20	304
1984	14.60	356
1985	15.50	400
1986	15.50	492
1987	17.90	520
1988	24.80	540
1989	* 27.90	560
1990	28.60	592

* The premium figure for 1989 does not include the added flat premium for the Medicare Catastrophic Coverage Act.

SOURCE: U.S. Health Care Financing Administration, 1990.

While the rate of increase in the Medicare hospital deductible has slowed in the past few years, the increase in the deductible between 1989 and 1990 was higher than the increase in the Consumer Price Index (CPI-W). Even though rate of increase has slowed somewhat, this was only after massive increases in the early 1980s. Over the 1981 through 1986 period, the deductible increased by at least 12 percent each year. For both 1982 and 1986, the deductible increased by well over 20 percent.

As for the Medicare Part B premium, the 1990 monthly premium of $28.60 is nearly ten times what the $3.00 monthly premium was when the Medicare program began in 1966. (See Table 1.2) Over the late 1970s and the 1980s, increases in the Medicare Part B premium have been erratic. In 1983 and 1986, the premium did not increase at all. On the other hand, the premium increased by over 10 percent each year for 1980, 1981, 1982, 1984, 1987, 1988, and 1989. The highest increase was for 1988 when the premium increased by 38.5 percent.

The future of the Medicare Part B premium can be seen from the President's 1991 budget (U.S. Health Care Financing Administration, 1990). (See Table 1.3) Under current law, the increases in the premium are limited to increases in the Social Security COLA (cost-of-living-adjustment). In this case, the premium would increase at the same rate as Social Security payments. The premium would increase from a 1990 level of $28.60 to a 1995 level of $34.80.

In his 1991 budget, the President is proposing to tie future Part B premium increases to Medicare Part B cost increases -- a rate which is almost always substantially higher than Social Security COLAs. According to Health Care Financing Administration estimates, acceptance of the President's proposal in part or in total would result in a substantially higher rate of increase than current law over the next five years. (See Table 1.3) If the President gets the premium increase and all the rest of the Part B cuts he has proposed, the monthly Part B premium would rise to $47.10 by 1995. On the other hand, if the President gets the premium increase but does not get any of his other Part B cuts, the monthly premium would rise faster and reach a level of $50.10 by 1995.

TABLE 1.3 — PROJECTED MEDICARE BENEFICIARY MONTHLY AND ANNUAL PART B PREMIUM FOR 1990 THROUGH 1995 UNDER THE PRESIDENT'S PROPOSAL AND UNDER CURRENT LAW.

Year	President's Proposed Premium Without Other Part B Cuts *	President's Proposed Premium With Other Part B Cuts *	Current Law Part B Premium
1990	--	--	28.60
1991	31.30	29.90	29.90
1992	35.20	33.30	31.10
1993	39.80	37.30	32.40
1994	44.70	41.90	33.60
1995	50.10	47.10	34.80

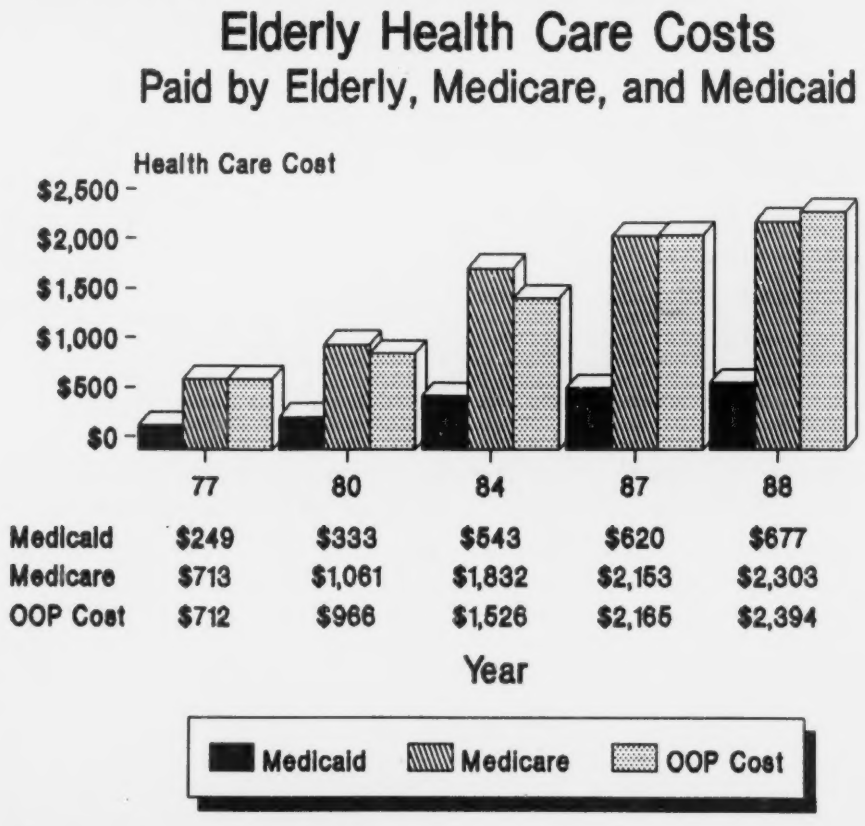
* For the President's proposed premiums, "without other Part B cuts" indicates what the premium would be if the President's other expenditure cuts in the Part B program were not enacted. "With other Part B Cuts" indicates what the premium would be if the President's other proposed Part B cuts were enacted.

SOURCE: U.S. Health Care Financing Administration, 1990.

ELDERLY HEALTH CARE COSTS. Adding to the picture of rising elderly health care costs is data on overall changes in health care costs for the elderly, paid for by the elderly, by Medicare, by Medicaid or by some other payer. This information is drawn from an analysis conducted by the House Select Committee in 1989 which used data from the Health Care Financing Administration and was published in the Chairman's report entitled "Health Care Costs for America's Elderly, 1977-88."

Especially for the elderly themselves and for Medicare, health care costs have risen rapidly. (See Figure 1.3) In 1977, total elderly health care costs were $1,785 per person. By 1988, those costs had risen to $5,749 -- more than three times the 1977 figure. Again this is a trend that does not show signs of abating as the increase from 1987 to 1988 was 8.7 percent -- over twice the rate for the Consumer Price Index (CPI-W). (See Table 1.4)

FIGURE 1.3 — GROWTH IN HEALTH CARE COSTS PAID BY THE ELDERLY, MEDICARE AND MEDICAID.



Source: House Committee on Aging, 1990

TABLE 1.4 — PER CAPITA HEALTH CARE COSTS EXPENDITURES FOR PERSONS AGED 65 AND OLDER IN 1977, 1980, 1987 AND 1988

Source Of Funds	Per Capita Health Expenditures 1977 $	1980 $	1987 $	1988 $
Total	1,785	2,515	5,288	5,749
Private	719	976	2,190	2,241
Consumer	**712**	**966**	**2,165**	**2,394**
Direct Out-of-Pocket	522	721	1,549	1,691
Insurance	115	148	434	463
Medicare Prem.	75	96	183	240
Other Private	7	10	25	27
Government	1,066	1,540	3,098	3,328
Medicare	713	1,061	2,153	2,303
Medicaid	249	333	620	677
Other Government	104	146	325	348

SOURCES: House Select Committee on Aging, October 1988; Health Care Financing Administration, July 1984 and October 1988; Census Bureau, 1988.

With respect to costs paid by the elderly themselves, the growth rate between 1977 and 1988 was slightly higher than the overall rate for all payers combined. As a result, the 1988 level is about 3.4 times the level of 1977. Again the trend shows no sign of slowing down as the annual increase between 1987 and 1988 was 10.6 percent -- over twice the rate for the Consumer Price Index (CPI-W).

Clearly, Medicare is facing problems with rising health care costs as well. Between 1977 and 1988, Medicare costs for the elderly grew from $713 per capita to $2,303 per capita -- a rate that is just slightly slower than the rate of growth for elderly out-of-pocket costs. The Medicare data for 1987 and 1988 shows Medicare costs continuing to grow over one and one-half times faster than the Consumer Price Index (CPI-W).

For the two primary payers of elderly health care, the elderly themselves and Medicare, health care costs have been and continue to be growing at very high rates and show no sign of a significant slowdown. The signs for slowing Medicare cost growth have improved due to aggressive cost cutting over the past decade. However, no one is sure of the consequences of that cost cutting for health care access and quality. For the elderly, there has been no progress since federal cost containment efforts fail to control many of their costs.

SLOW GROWTH IN ELDERLY INCOME

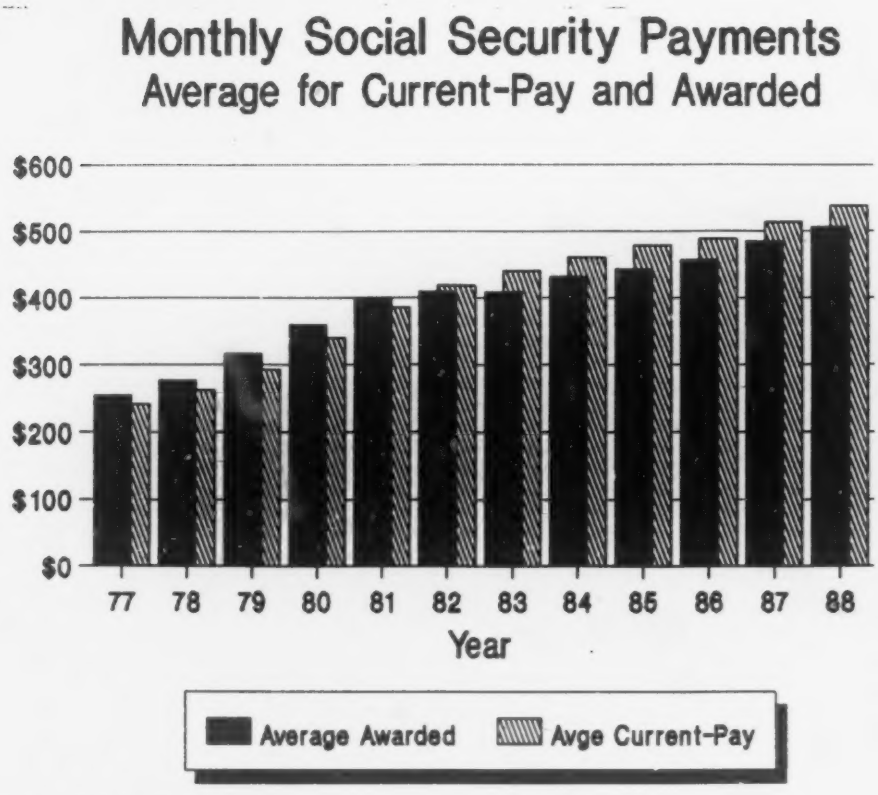
In order to provide a better perspective on the problem created by rapidly rising health and long term care costs, there is a need to look at what is happening to the elderly's ability to pay these costs. Since health and long term care costs increases show little sign of slowing down, it is also important to look at both the past and the future. Though some elderly are already in severe difficulty, the future is likely to be even more problematic.

SOCIAL SECURITY COST-OF-LIVING-ADJUSTMENTS. Social Security, a primary source of income for millions of current and future elderly, ties its annual cost-of-living-adjustments (COLAs) to the Consumer Price Index for Urban Wage Earners (CPI-W). Since 1978, Social Security COLAs have fluctuated greatly as has general price inflation. (See Figure 2.1 and Table 2.1) COLAs have ranged everywhere from as low as 1.3 percent to as high as 14 and 11 percent in 1980 and 1981 respectively. For the 1977 through 1990 period, the COLA averaged 6.1 percent annually.

In the President's 1991 budget proposal, the Administration estimates that the COLA for the upcoming year will be 3.9 percent and the projected average for 1991 through 1995 is 3.7 percent. While the Social Security COLA has kept pace with general inflation, questions remain over how well the COLA measures change in elderly costs. As one prime example, health care costs have consistently outpaced inflation (as noted above) and are likely to do so in the future.

SOCIAL SECURITY MONTHLY BENEFIT PAYMENTS. Another way of looking at changes in the elderly's ability to pay is to look at average monthly Social Security payments for retired workers. (See Figure 2.1 and Table 2.1) Over the 1977 through 1988 period, there has been growth, but again at a relatively slow rate. Between 1977 and 1988, the average monthly Social Security benefit for all of those in current-pay status (i.e., all those receiving payments in that year) slightly more than doubled from $243 per month to $537 per month.

FIGURE 2.1 — TRENDS IN SOCIAL SECURITY COST-OF-LIVING ADJUSTMENTS FOR 1977 THROUGH 1995 AND AVERAGE MONTHLY SOCIAL SECURITY PAYMENTS TO RETIRED WORKERS FOR 1977 THROUGH 1988.



Source: U.S. Social Security Administration, 1990

If one looks at monthly benefits for those beneficiaries awarded Social Security benefits in a given year, the growth is slower. In part, this is due to the fact that retirees in the late 1970s and very early 1980s received slightly higher Social Security payments than those retiring after 1981. Between 1977 and 1988, the average monthly benefit awarded slightly less than doubled, as it grew from $255 per month to $505 per month. For those years, the average rate of growth was 6.5 percent annually. Over the past seven years, the average rate of growth was substantially less for average monthly benefits awarded (3.4 percent annually) and for the general rate of inflation (3.6 percent annually).

TABLE 2.1 — SOCIAL SECURITY COST-OF-LIVING-ADJUSTMENTS AND PAYMENTS FOR 1977 THROUGH 1995.

Year	Social Security COLA (Percent)	Retired Workers Average Monthly Benefit	
		Current-Pay Status	Benefit Awarded
1977	6.4	$243	$255
1978	5.9	263	278
1979	6.5	294	317
1980	9.9	341	360
1981	14.3	386	400
1982	11.2	419	409
1983	7.4	441	410
1984	3.5	461	430
1985	3.5	479	443
1986	3.1	488	457
1987	1.3	513	484
1988	4.2	537	505
1989	4.0	na	na
1990 *	4.7		
1991 *	3.9		
1992 *	4.1		
1993 *	3.8		
1994 *	3.6		
1995 *	3.3		

* Projections as published in the President's "Budget of the United States Government, Fiscal Year 1991."

SOURCE: U.S. Social Security Administration, 1990.

PUBLIC AND PRIVATE PENSIONS. With respect to public and private pensions, considerably less information is available to describe changes over time. What is known about pensions indicates that less attention is given to keeping pace with regular inflation, let alone health cost inflation. Anecdotal data and older studies suggest that most private pensions do not have automatic cost-of-living-adjustments. In fact, private pension adjustments that are made are often below regular inflation.

In the case of Federal retiree pension programs, the prospect for an annual cost-of-living-adjustment is uncertain. To take the most recent example, the 1991 President's budget proposes to give civilian and military retirees no COLA for 1991 and to have future COLAs tied to the overall consumer price index minus one percent.

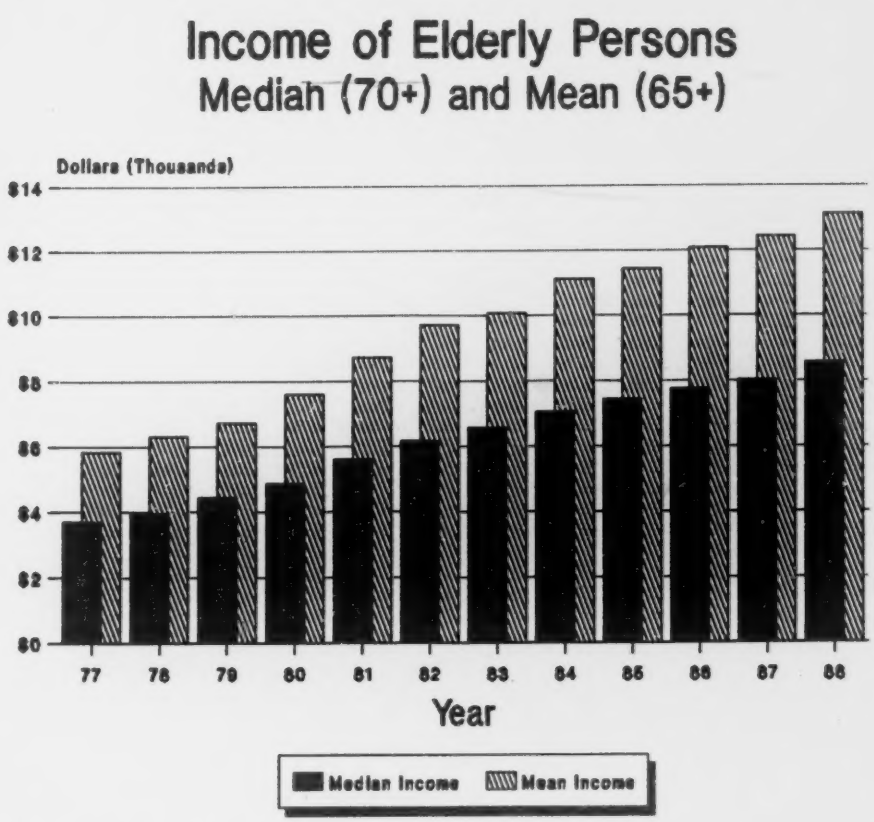
The recent trend for private pension coverage is one of little growth. While the elderly who retire today and in the next several years have relatively high rates of pension coverage, the prospect for later generations is less bright. Further, employer contributions to pension plans are not as high as several years ago.

In the near term, a larger proportion of elderly will have private pensions which will be relatively substantial when they retire. For the longer term, two problems emerge. First, the elderly who retire today or in the next few years will see a rapid erosion of the value of their pensions relative to the cost of health and long term care. The elderly retiring in the decades ahead may not have as high a rate of coverage or as high of a starting point for pension payments. In either case, these retirees will lose ground as they spend ten to thirty years in retirement with pensions not keeping pace with overall inflation or with the higher health care cost inflation.

MEDIAN INCOME FOR ELDERLY OVER AGE 70. Beyond Social Security payments and pensions, a way to look at elderly income is to focus on median income (the income level at which one-half the elderly earn more and one-half the elderly earn less) and on the older elderly, those aged 70 and above. This older group is more likely to face higher health and long term care costs with less income.

Median income for persons aged 70 and over in 1988 was $8,557, considerably less than the mean elderly income in 1988 of $13,131. (See Figure 2.2 and Table 2.2) In recent years, the rate of growth in the median income figure has kept pace with the elderly mean income figure. At least one reason for this is because the group retiring in the late 1970s and very early 1980s received slightly higher Social Security payments. However, the prospects for the future are not as bright, since the group that was just entering their 70s after 1981 generally received lower Social Security payments.

FIGURE 2.2 — TRENDS IN ELDERLY MEAN AND MEDIAN INCOME FOR 1977 THROUGH 1988.



Source: U.S. Bureau of the Census, 1990

Though growth in median income for those aged 70 and above has been similar to growth in mean income for those aged 65 and above, three problems are indicated for the future. First is the fact that one-half of older elderly -- about fourteen and one-half million people -- have incomes under $8,557 per year, leaving them very little margin when it comes to health and long term care costs. Secondly, the primary reason this level has gone up is because a slightly wealthier cohort of elderly have moved into this age group. The next cohorts are unlikely to be as well off. Third, even if these people are better off coming into their 70s, they are likely to live another decade and consistently be losing ground as their incomes fail to keep pace with overall inflation and health and long term care cost inflation.

TABLE 2.2 — INCOME OF ELDERLY PERSONS FOR 1977 THROUGH 1988.

Year	Aged 65 and Over Mean Income	Aged 70 and Over Median Income
1977	$5,855	$3,712
1978	6,288	3,951
1979	6,709	4,428
1980	7,616	4,872
1981	8,738	5,595
1982	9,716	6,179
1983	10,094	6,556
1984	11,127	7,045
1985	11,451	7,456
1986	12,074	7,729
1987	12,430	8,044
1988	13,131	8,557

SOURCE: U.S. Bureau of the Census, 1990.

ELDERLY MEAN INCOME. Another view is provided by examining mean (or average) income per person aged 65 and older, a figure that has increased steadily in recent decades and reached $13,131 in 1988, as compared to $5,855 in 1977. (See Figure 2.2 and Table 2.2) Over the period between 1977 and 1988, elderly mean income rose at an average annual rate of 7.7 percent -- about a one and one-half percent higher rate than for Social Security increases and overall inflation. As has been the case with Social Security and overall inflation, the rate of increase has slowed in recent years. Over the most recent four-year period (1985-1988), the annual rate of increase in mean elderly income averaged 4.2 percent -- just slightly higher than the 3.6 percent for overall inflation.

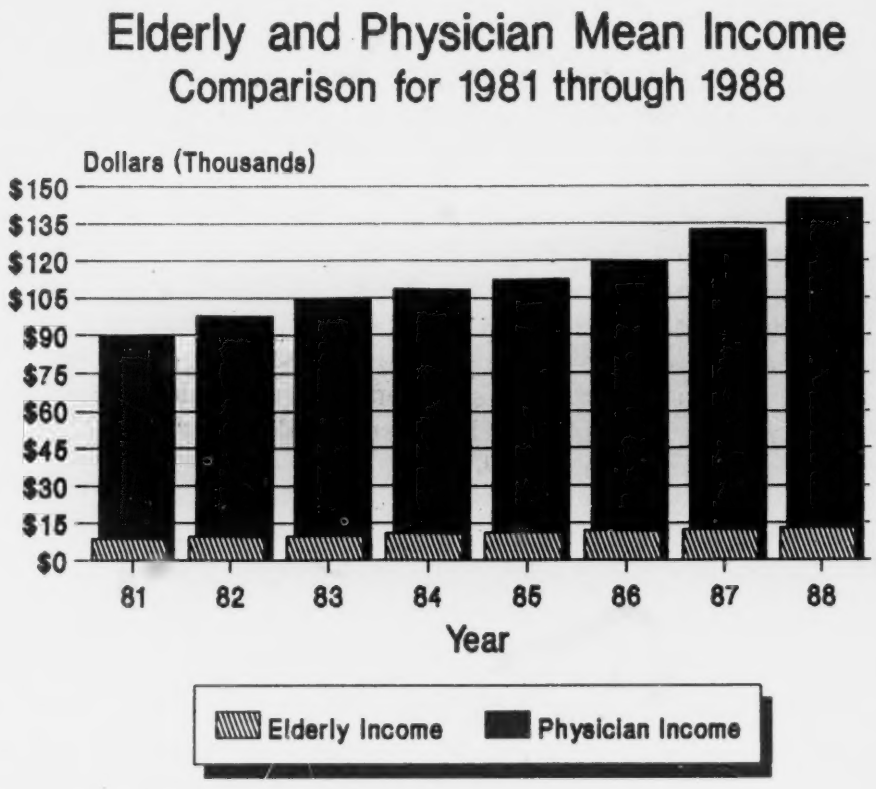
ELDERLY MEAN INCOME AS COMPARED TO PHYSICIAN MEAN INCOME. While elderly mean income has experienced some growth in the 1980s, mean incomes for physicians, a primary source of health care for older Americans, has grown much faster. Starting from a level of $89,900 in 1981, average physician net annual income rose to $144,700 in 1988. (See Table 2.3 and Figure 2.3) During the same period, elderly mean annual income went from a level of $8,738 in 1981 to $13,131 in 1988 and is only one-eleventh the level of physician net income. Over the seven year period (1981-88), average net physician income, for all physicians combined, increased by 61 percent. Three physician specialties (surgery, radiology, anesthesiology) grew at even higher rates ranging from 69 to 81 percent for the 1981-88 period. General and family practice physicians only increased 32 percent over this period. As a group, the surgeons were among the fastest growing and were the highest paid, reaching a 1988 average net income of $207,500.

TABLE 2.3 — PHYSICIAN MEAN NET INCOME AND ELDERLY MEAN INCOME FOR 1981 THROUGH 1988.

Year	Aged 65 and Over Mean Income	Physician Mean Income
1981	8,738	89,900
1982	9,716	97,700
1983	10,094	104,100
1984	11,127	108,400
1985	11,451	112,200
1986	12,074	119,500
1987	12,430	132,300
1988	13,131	144,700

SOURCE: Bureau of the Census, 1990; and "Socioeconomic Characteristics of Medical Practice 1989," AMA, 1990.

FIGURE 2.3 — TRENDS IN PHYSICIAN MEAN NET INCOME AND ELDERLY MEAN INCOME FOR 1981 THROUGH 1988.



Source: U.S. Bureau of the Census, 1990
and American Medical Association, 1990

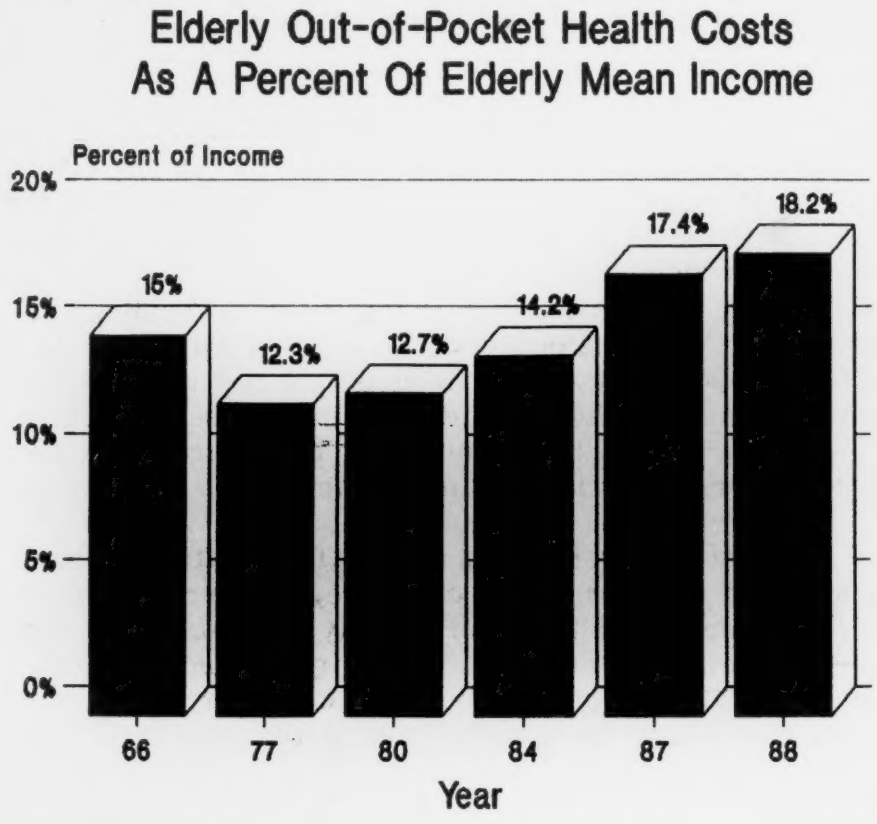
ELDERLY LOSING GROUND AS HEALTH CARE COSTS ABSORB HIGHER PERCENTAGE OF THEIR INCOME.

What the previous data suggest is that it is true that the elderly today, on average, are somewhat better off in terms of income than previous generations of elderly. However, the same data suggest large number of elderly are still in deep trouble, including older women and racial and ethnic minorities. The data also suggest that the retirees of the 21st century, on average, will not be better off. Any advantage that the elderly may have by entering retirement with higher incomes than a decade ago will quickly be lost as health and long term care costs absorb ever larger proportions of that income.

Measured against a number of indicators of income, health and long term care costs are, on average, absorbing ever larger percentages of elderly income. For elderly persons entering retirement in any given year, they face a continual erosion of their income as health care costs rise more than one and one-half times faster than their income.

ELDERLY OUT-OF-POCKET HEALTH COSTS AS COMPARED TO ELDERLY MEAN INCOME. As described earlier, the House Committee on Aging analyzed out-of--pocket costs for selected years from 1977 to 1988. The results of that analysis show that elderly out-of-pocket costs have risen from 12.3 percent of elderly income in 1977 to 18.2 percent of income in 1988. (See Figure 3.1 and Table 3.1) The 1988 level is also substantially higher than the 15 percent level in 1966, the year the Medicare and Medicaid programs began. All indications are that this trend of costs outpacing income will continue into the foreseeable future and that health costs are likely to reach 20 percent of elderly income by the early 1990s.

FIGURE 3.1 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS AS A PERCENTAGE OF ELDERLY INCOME FOR 1977, 1980, 1984, 1987 AND 1988.



Source: House Committee on Aging, 1990

ELDERLY OUT-OF-POCKET HEALTH COSTS AS COMPARED TO ELDERLY SOCIAL SECURITY PAYMENTS. Another way of looking at health care costs versus income is to compare out-of-pocket health costs with Social Security payments. As shown in Figure 3.2, annual average out-of-pocket health costs ($712) approximated three months worth ($729) of average Social Security payments (current payment status) in 1977. Eleven years later, the two figures were no longer close. In 1988, three months worth of Social Security payments totaled $1,611 while annual out-of-pocket health care costs totaled $2,394 -- 50 percent higher.

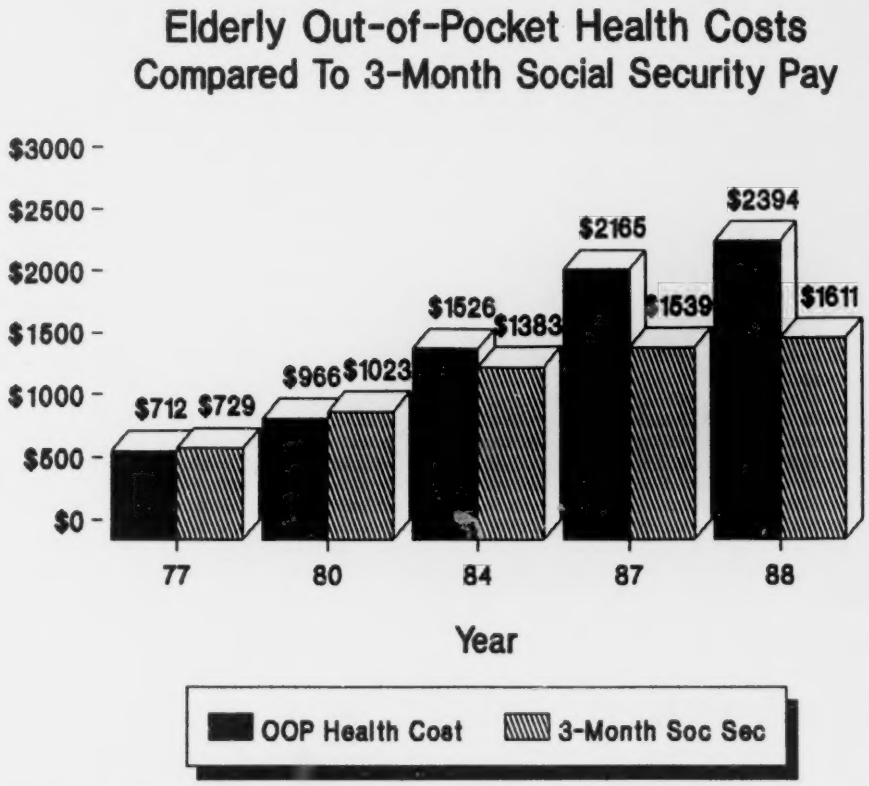
TABLE 3.1 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS FOR 1965, 1977, 1980, 1984 AND 1988.

Year	Elderly Out-of-Pocket Health Care Costs	Percentage of Elderly Income
1988	$2,394	18.2%
1987	2,165	17.4%
1984	1,526	14.2%
1980	966	12.7%
1977	712	12.3%
1966	300	15%

SOURCES: House Select Committee on Aging, October 1988; Health Care Financing Administration, July 1984 and October 1988; Census Bureau, 1988.

For the average senior citizen receiving Social Security, it is taking more and more of their Social Security checks to cover health and long term care costs. In 1977, the average senior citizen used just under three months worth of Social Security checks to cover his or her out-of-pocket health care costs. (See Figure 3.3) By 1988, it took the average senior citizen four and one-half months worth of Social Security checks to cover those health costs. For those elderly receiving less than the average Social Security check or having higher than average health and long term care costs, the situation is worse.

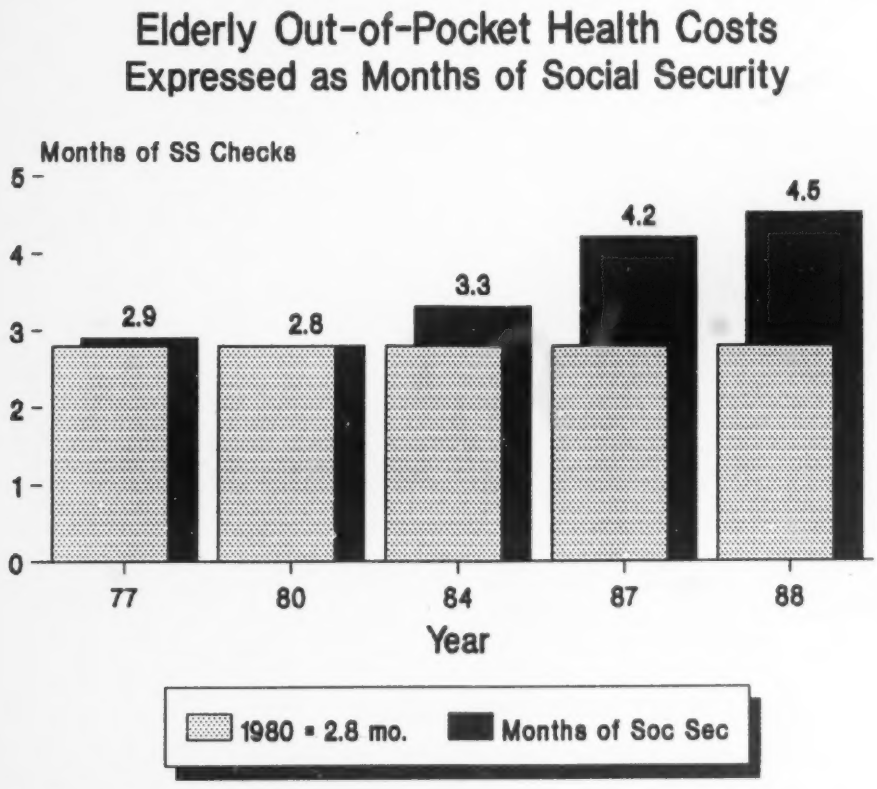
FIGURE 3.2 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS AS COMPARED TO THREE MONTHS WORTH OF SOCIAL SECURITY PAYMENTS (Average Monthly Benefits (Current-payment Status) for Retired Workers) FOR 1977, 1980, 1984, 1987 AND 1988.



Source: House Committee on Aging, 1990, U.S. Social Security Admin., 1990

MEDICARE DEDUCTIBLES AND PREMIUMS AS COMPARED TO ELDERLY SOCIAL SECURITY PAYMENTS. A different measure of health care cost pressures on the elderly are changes in elderly Medicare payments -- the Part A deductible and Part B premium. As noted earlier, the Medicare Part B deductible has not gone up as rapidly as elderly income and has been one small piece of good news in keeping costs affordable.

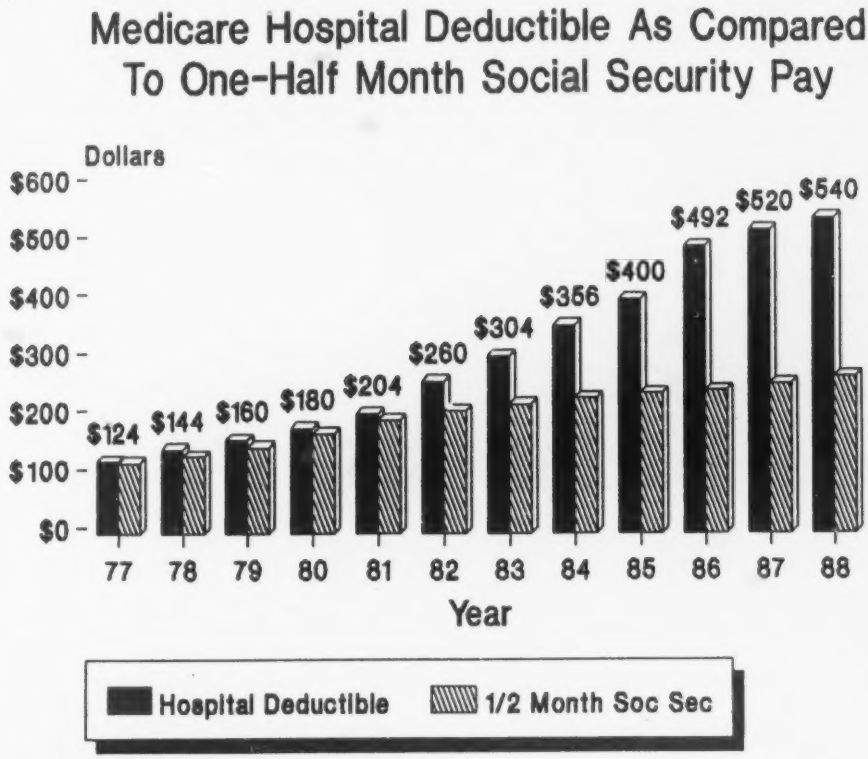
FIGURE 3.3 — ELDERLY OUT-OF-POCKET (CONSUMER) HEALTH CARE COSTS EXPRESSED IN TERMS OF NUMBER OF MONTHS OF SOCIAL SECURITY PAYMENTS (Average Monthly Benefits (Current-payment Status) for Retired Workers) FOR 1977, 1980, 1984, 1987 AND 1988.



Source: House Committee on Aging, 1990, and U.S. Social Security Adm., 1990

In the case of the Medicare Part A hospital deductible, the increases have been substantial. (See Figure 3.4) As one indicator, the hospital deductible was $124 in 1977 -- roughly equivalent to one-half month's Social Security payment ($122) in that same year. Eleven years later, that same one-half month Social Security payment had grown to $269, a little over twice the 1977 level. During the same period, the Medicare Part A hospital deductible jumped to $540 -- over four times the level in 1977 and twice the one-half month Social Security payment for 1988.

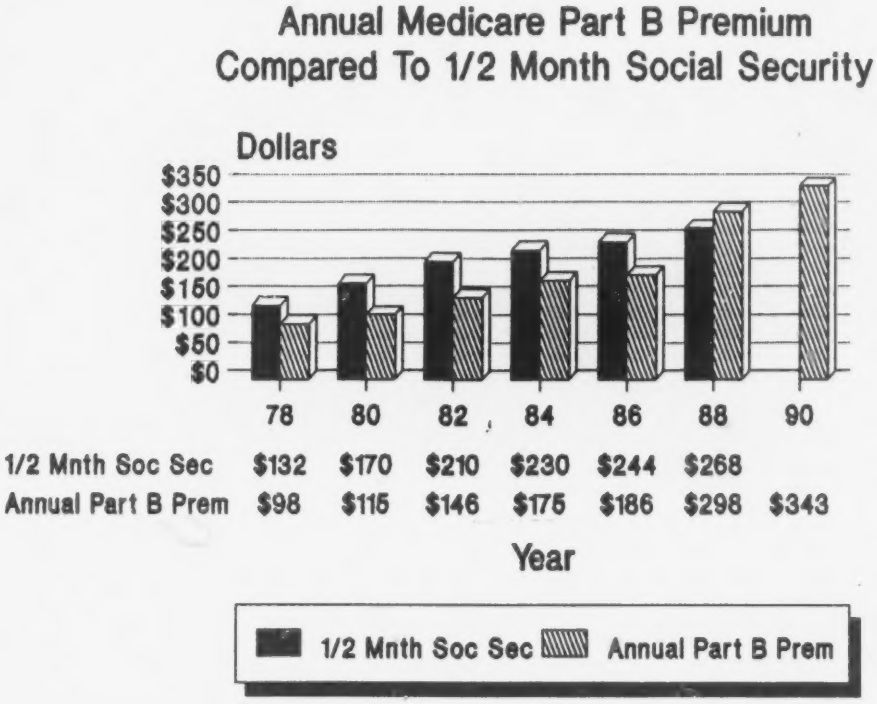
FIGURE 3.4 — MEDICARE PART A HOSPITAL DEDUCTIBLE AS COMPARED TO ONE-HALF AVERAGE MONTHLY SOCIAL SECURITY BENEFIT FOR RETIRED WORKERS FOR 1977 THROUGH 1988.



Source: House Committee on Aging, 1990, Health Care Financing Admin., 1989, and Social Security Admin. 1990

A similar pattern holds for the Medicare Part B premium as compared to Social Security payments. (See Figure 3.5) In 1977, the annual Part B premium was $92, substantially less than one-half of the monthly Social Security payment for 1977. By 1988, the annual Part B premium had risen to $298, substantially more than one-half of the monthly Social Security payment.

FIGURE 3.5 — MEDICARE PART B PREMIUM AS COMPARED TO ONE-HALF AVERAGE MONTHLY SOCIAL SECURITY BENEFIT FOR RETIRED WORKERS FOR 1977 THROUGH 1995.



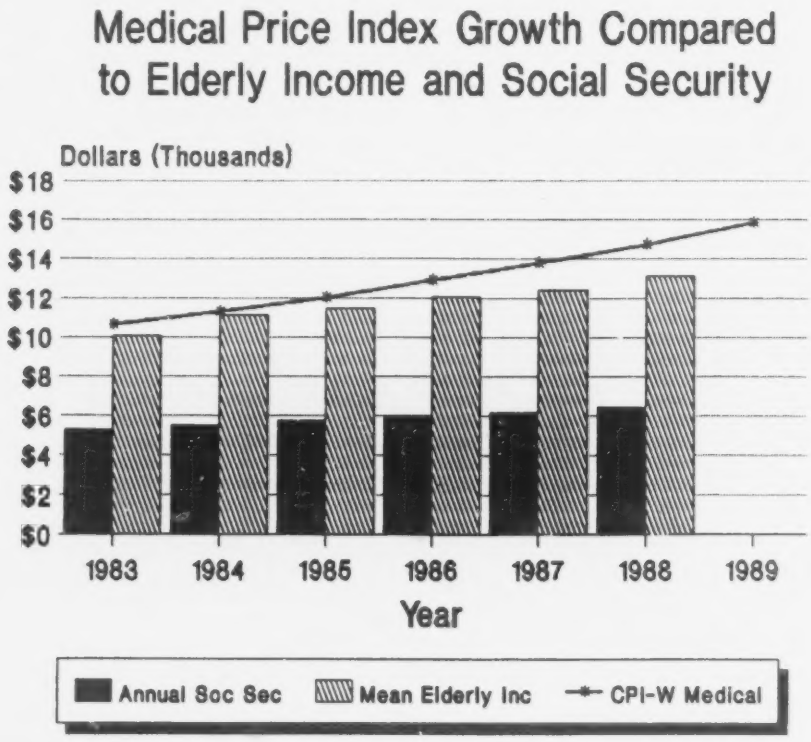
Source: House Committee on Aging, 1990, Health Care Financing Admin., 1990 and Social Security Admin., 1990

Looking ahead, the President's 1991 Budget proposes a permanent increase in the Part B premium by tying it to increases in overall Part B costs. Under current law, the premium cannot increase faster than the Social Security COLA and is estimated to be $34.80 per month in 1995. If the President's proposal is enacted into law, the Medicare Part B premium would reach $47 per month in 1995, assuming the President's other Part B cuts were enacted. If the President's other Part B cuts were not enacted, the Part B premium would be higher at $50 per month.

Over the 1991-95 period, the President's proposal would increase the Part B premium much faster than the Social Security COLA. Under the President's best case, where he gets all of his other Part B cuts, the premium would rise an average of 9.6 percent annually as compared to average Social Security COLAs of 3.7 percent. If Medicare Part B is not cut as he proposes, the premium would rise an average of 10.0 percent annually. In both cases, the elderly lose ground as Social Security payments grow more slowly than the Part B premium. Another source of concern is over the access and quality consequences for the elderly if the President does get his other Medicare Part B and Part A cuts.

MEDICAL CARE PRICES AS COMPARED TO ELDERLY INCOME. Most of the previous analysis has focused on senior citizens because they are most likely to have the combination of substantial health and long term care costs and relatively fixed incomes. However, when medical prices are charted against elderly income, a picture is drawn that also applies to persons of any age who have major health costs and relatively fixed incomes. As detailed earlier, medical price increases for the past seven years are much higher than increases in several indicators of elderly income. (See Figure 3.6) On average between 1983 and 1989, medical prices rose twice as fast as did the average monthly Social Security payment and the Consumer Price Index (CPI-W), the basis for setting Social Security COLAs. For the same period, growth in medical price also easily outdistanced growth in mean income for those aged 65 and older and median income for those aged 70 and older.

FIGURE 3.6 — INCREASES IN MEDICAL CARE PRICES AS COMPARED TO SOCIAL SECURITY, AND ELDERLY MEAN AND MEDIAN INCOME.



Source: Bureau of Labor Statistics, 1990, Bureau of Census, 1989 and Social Security Administration, 1990

CONCLUSION: "CONSUMER COST" CONTAINMENT AS CRITICAL OR MORE THAN FEDERAL, STATE AND EMPLOYER COST CONTAINMENT

As this analysis clearly documents, the elderly, as well as any other group of people with relatively fixed incomes and substantial health care costs, have a problem now and are likely to have a bigger problem in the future. Though the problem is acute for all low and middle income elderly, it is particularly acute for those live in the "high risk zone," a place where incomes are limited and health care costs may be high.

Unless there is a significant cost containment intervention on behalf of beneficiaries, there is every reason to believe that the future is likely to look much like the past where health care costs grow everywhere from one and one-half to two times faster than general inflation and than elderly income.

There is little doubt that federal and state governments will continue to pursue cost containment to restrain costs for both Medicare and Medicaid. There is also little doubt that employers and unions will continue cost containment efforts for the care they buy for the employed. What continues to be in doubt is whether or not there will be a significant cost containment effort to restrain out-of-pocket costs for Medicare beneficiaries and to restrain out-of-pocket costs for the uninsured and for those not represented by employers and unions.

What is missing and desperately needed is a coordinated cost containment approach that restrains cost for all payers, whether they be government, employers, or individuals. To be successful, a coordinated strategy must be applied fairly so that health care providers receive reasonable payment for their services. It must be applied with great care to ensure that health and long term care quality and accessibility do not suffer.

○

ERRATA

EMPTYING THE ELDERLY'S POCKETBOOK— GROWING IMPACT OF RISING HEALTH CARE COSTS

A REPORT

BY THE

CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MARCH 1990

Comm. Pub. No. 101-746

Printed for the use of the Select Committee on Aging

This document has been printed for informational purposes only. It does not represent either findings or recommendations adopted by this Committee.

U.S. GOVERNMENT PRINTING OFFICE

27-633 WASHINGTON : 1990

H142-5

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

TABLE 1.4 — PER CAPITA HEALTH CARE COSTS EXPENDITURES FOR PERSONS AGED 65 AND OLDER IN 1977, 1980, 1987 AND 1988

	Per Capita Health Expenditures			
	1977	1980	1987	1988
Source Of Funds	$	$	$	$
Total	1,785	2,515	5,288	5,749
Private	719	976	2,190	2,421
Consumer	**712**	**966**	**2,165**	**2,394**
Direct Out-of-Pocket	522	721	1,549	1,691
Insurance	115	148	434	463
Medicare Prem.	75	96	183	240
Other Private	7	10	25	27
Government	1,066	1,540	3,098	3,328
Medicare	713	1,061	2,153	2,303
Medicaid	249	333	620	677
Other Government	104	146	325	348

SOURCES: House Select Committee on Aging, October 1988; Health Care Financing Administration, July 1984 and October 1988; Census Bureau, 1988.

NOTE: This chart in the original report contained a typographical error for "private" expenditures for 1988. Instead of being $2,241 per capita for 1988, the correct figure is $2,421 for 1988. The above chart contains that correction and should replace the chart in the original report.